

From:

To: HRA

05/02/2008 15:34

#194 P.002/015

04/23/2008 03:58 FAX 2024429430

HRA

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 000}	INITIAL COMMENTS  A follow-up to the 2/14/2008 recertification survey was initiated on 4/3/2008 and was completed on 4/4/2008. The survey was conducted to assess the level of compliance to the deficiencies cited in the previous report and as presented in their Plan of Correction (POC). The results of the survey were based on observation, staff interviews, as well as a review of the client and administrative records, including a review of the unusual incident reports.	{W 000}	Received on 5/2/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002		
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the implementation of its written policies and procedures as required by this section for all clients residing in the facility.  The finding includes:  The facility was cited during the 2/14/2008 survey for failing to implement policies on reporting of unusual incidents. The provider's Plan of Correction (POC) detailed that "in the future ... staff will be required to attend additional training on Incident Management Policies and reporting injuries to Nursing staff." Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/3/2008 at 3:11pm revealed there has been no training on the incident management policy or on the methodology of reporting injuries to the Nursing	{W 149}	The facility will provide training on incident management, and reporting injuries to nursing staff.	5/8/08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Constance C. Reese* *Program Director* *5-2-08*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

#194 P.003/016

222

PRINTED: 04/23/2008  
FORM APPROVED  
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NAME OF PROVIDER OR SUPPLIER  C M S				STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
(W 149) (W 159)	<p>Continued From page 1</p> <p>staff since the 2/14/2008 survey.</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for two clients residing in the facility. [Clients #1 and #4]</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The Qualified Mental Retardation Professional (QMRP) failed to ensure staff received the proper and necessary training on a client's orthotic device. [Reference W189]</li> <li>2. The Qualified Mental Retardation Professional (QMRP) failed to ensure the proper oversight and monitoring of a client's failure to show progress on his habilitative programming. [Reference W257]</li> <li>3. The Qualified Mental Retardation Professional (QMRP) failed to ensure clients received the proper and necessary dental services. [Reference W356]</li> <li>4. The Qualified Mental Retardation Professional (QMRP) also failed to ensure client's received the proper and necessary adaptive equipment. [Reference W436]</li> </ol>	(W 149) (W 159)	<ol style="list-style-type: none"> <li>1. Client #4 will receive orthotic devices when Medicaid authorize payment for the orthotic devices. The facility will provide written documentation indicating when Client#4 was measured for the orthotic devices.</li> <li>2. The nursing staff will provide documentation that Client#1 was unable to participate in his medication program due to his fractured toes.</li> <li>3. QMRP will provide documentation where Client#1 refused dental care twice. Client#1 will return to the dentist again in an attempt to provide him with dental care.</li> <li>4. Cross reference W159</li> </ol>	5/15/08       5/15/08    5/15/08			

From:

To: HRA

05/02/2008 15:35

#194 P. 004/015

04/23/2008 03:56 FAX 2024428400

BPA

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
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{W 189}	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that staff received the proper and necessary training on a client's adaptive equipment as required by this section for one of eight clients residing in the facility. [Client #4]</p> <p>The finding includes:</p> <p>The facility was cited during the 2/14/2008 survey for failing to ensure that staff received training on Client #4's adaptive equipment (gait belt and leg brace). The facility's Plan of Correction (POC) detailed that "the facility will train staff on how to assist [Client #4] in walking with the gait belt and putting on his braces." This corrective measure was to be completed by 3/19/2008.</p> <p>Client #4 was observed on the afternoon of 4/4/2008 wearing his gait belt but, he was without his leg brace. Staff was observed using the gait belt, but it was not clear why he was not wearing his leg brace. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 3:37pm revealed the leg braces were not available at the time of survey and that the provision of that orthotic device was pending. Record review revealed the facility was not able to complete the training on the use of the leg braces, being that the orthotic device has not been provided. [Reference W436]</p>	{W 189}	QMRP will provide training for staff once Client#4 receives his braces.	6/1/08	

From:

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05/02/2008 15:35

#194 P.005/016

04/23/2008 03:56 FAX 2024428430

HRA

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OMB NO. 0938-0391

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W 257	<p>483.440(f)(1)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to address the documented lack of progression by a client on his self medication administration program one of eight clients residing in the facility. [Client #1]</p> <p>The finding includes:</p> <p>The facility was previously cited for failing to ensure accurate documentation on a client's program during the 2/14/2008 survey. The facility was previously cited for failing to meet the requirements as laid out in W262. Record review on 4/4/2008 at 3:45pm revealed Client #1 has been refusing the first three steps of his self medication program since the date of survey. The first three steps of the self medication program are as follows:</p> <ol style="list-style-type: none"> <li>1. Approaches nurse for meds independently.</li> <li>2. Will pour cup of water for meds.</li> <li>3. Will punch out meds with physical assistance.</li> </ol> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) at 3:55pm revealed she was not aware Client #1 was progressing poorly on his self medication program. The facility failed to ensure the</p>	W 257	Cross reference W159	5/15/08	

From:

To: HRA

05/02/2008 15:38

#194 P.006/015

04/23/2008 03:00 PM 2029228400

END

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0936-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
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W 257  (W 356)	<p>Continued From page 4</p> <p>necessary oversight and intervention to ensure the proper supports when a client's is failing to show progress in a habilitation program.</p> <p>483.450(g)(2) COMPREHENSIVE DENTAL TREATMENT</p> <p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the provision of timely and necessary dental services and treatment for one of eight clients residing in the facility. [Client #1]</p> <p>The findings include:</p> <p>The facility was previously cited for not ensuring timely dental services for its residents. According to the citation levied during the 2/14/2008 survey, the facility took the client to receive dental services on 2/18/2007, 7/16/2007, and again on 1/29/2008, but the client did not received the following services. The reason(s) why the services were not render was unknown to the staff.</p> <ol style="list-style-type: none"> <li>1. Recommended to receive scaling due to heavy calculus deposits</li> <li>2. Recommended to receive partial denture</li> <li>3. Treatment to address Gingivitis</li> <li>4. Treatment to address the Carious lesion on Tooth #12</li> <li>5. Recommended to receive Prophylaxis and polishing</li> </ol>	W 257  (W 356)	Cross reference W159	5/15/08	

From:

To: HRA

05/02/2008 15:36

#194 P.007/015

04/23/2008 03:57 FAX 2024428400

DRA

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
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{W 356}	Continued From page 5 6. Extraction of Tooth #12  The facility's Plan of Correction (POC) detailed that they would ensure that "Client #1 will return to the dentist for dental follow-up". This treatment was to be completed by 3/26/2008 as presented in their POC. Record review revealed Client #1 was taken for dental treatment on 3/5/2008, but he refused treatment. The dentist recommended during the 3/5/2008 consultation to have this client sedated prior to receiving treatment. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 4:16pm revealed that the Human Rights Committee (HRC) would have to approve the action, and then the client's brother would also have to consent. There is was no evidence presented on or file at the time of survey to substantiate that this client has received the proper and necessary treatment as identified by his dentist to date.	{W 356}			
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT  The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure the provision of a leg brace for one of eight clients residing in the facility. [Client #4]  The finding includes:	{W 436}	Cross reference W159	5/15/08	

From:

To: HRA

05/02/2008 15:36

#194 P.008/015

04/23/2008 03:31 FAX 2024940900

MAY

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
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{W 436}	Continued From page 6  Client #4 was observed on the afternoon of 4/4/2008 wearing his gait belt but, he was without his leg brace. Staff was observed using the gait belt, but it was not clear why he was not wearing his leg brace. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 3:37pm revealed the leg braces were not available at the time of survey and that the provision of that orthotic device was pending. Record review revealed that Client #4 was taken to an orthopedic specialist to be refitted for the new braces on 2/18/2008, but there was no evidence at the time of survey to substantiate that the facility followed through to ensure that this client received his adaptive equipment in a timely manner.	{W 436}			

04/23/2000 03:21 PM 404960000

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**#184 P.008/015**

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

JUL 12 1964

**DATE**

1 of 7



From:

To: HRA

05/02/2008 15:37

#194 P.010/015

04/23/2008 03:57 FAX 2024428430

HRA

PRINTED: 04/23/2008  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  03G035	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED R 04/04/2008
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(I 090)	Continued From page 1  bathroom and no paper towel holder was available in the first floor bathroom.  2. New small areas of brown stains were again observed on the ceiling in the dining room. According to the Qualified Mental Retardation Professional (QMRP), the areas were previously repaired and she is not sure how or why the stains are returning.  Exterior:  1. Several torn areas were observed in the carpet installed on the steps leading to the front porch, which created a potential hazard.  2. A torn area was observed in the carpet where back porch is attached to the first step, which created a potential hazard.	(I 090)	Ceiling tiles were replaced.        Carpet was replaced.    Carpet was replaced.	4/30/08        4/7/08   4/7/08
(I 222)	3510.3 STAFF TRAINING  There shall be continuous, ongoing in-service training programs scheduled for all personnel.  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that staff received the proper and necessary training on a resident's adaptive equipment as required by this section for one of eight residents residing in the facility. [Resident #4]  The finding includes:  The facility was cited during the 2/14/2008 survey for failing to ensure that staff received training on Resident #4's adaptive equipment (gait belt and leg brace). The facility's Plan of Correction (POC) detailed that "the facility will train staff on	(I 222)	Cross reference W159 Training was provided for the gait belt.  Training for braces will be completed when braces are in the facility.	5/15/08 3/19/08  6/1/08

Health Regulation Administration  
STATE FORM

JUL12

If continuation sheet, 2 of 7

From:

To: HRA

05/02/2008 15:37

#194 P.011/015

04/23/2008 03:51 FAX 2024429200

BAA

PRINTED: 04/23/2008  
FORM APPROVED

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(1222)	Continued From page 2  how to assist [Resident #4] in walking with the gait belt and putting on his braces. " This corrective measure was to be completed by 3/19/2008.  Resident #4 was observed on the afternoon of 4/4/2008 wearing his gait belt but, he was without his leg brace. Staff was observed using the gait belt, but it was not clear why he was not wearing his leg brace. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 3:37pm revealed the leg braces were not available at the time of survey and that the provision of that orthotic device was pending. Record review revealed the facility was not able to complete the training on the use of the leg braces, being that the orthotic device has not been provided. [Reference W436]	(1222)			
1392	3520.2(b) PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:  (b) Dentistry:  This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the provision of timely and necessary dental services and treatment for one	1392	Cross reference W159	5/15/08	

Health Regulation Administration  
STATE FORM

JUL12

If continuation sheet 4 of 7

From:

To: HRA

05/02/2008 15:38

#194 P.012/015

04/23/2008 03:57 FAX 2024428430

DMS

PRINTED: 04/23/2008  
FORM APPROVED

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1392	<p>Continued From page 3</p> <p>of eight residents residing in the facility. [Resident #1]</p> <p>The findings include:</p> <p>The facility was previously cited for not ensuring timely dental services for its residents. According to the citation levied during the 2/14/2008 survey, the facility took the resident to receive dental services on 2/18/2007, 7/18/2007, and again on 1/29/2008, but for some reason the resident never received the following services:</p> <ol style="list-style-type: none"> <li>1. Recommended to receive scaling due to heavy calculus deposits</li> <li>2. Recommended to receive partial denture</li> <li>3. Treatment to address Gingivitis</li> <li>4. Treatment to address the Carious lesion on Tooth #12</li> <li>5. Recommended to receive Prophylaxis and polishing</li> <li>6. Extraction of Tooth #12</li> </ol> <p>The facility's Plan of Correction (POC) detailed that they would ensure that "Resident #1 will return to the dentist for dental follow-up". This treatment was to be completed by 3/28/2008 as presented in their POC. Record review revealed Resident #1 was taken for dental treatment on 3/5/2008, but he refused treatment. The dentist recommended during the 3/5/2008 consultation to have this resident sedated prior to receiving treatment. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 4:18pm revealed that the Human Rights Committee (HRC) would have to approve the action, and then the resident's brother would also have to consent. There was no evidence presented on or file at the time of survey to substantiate that this resident has</p>	1392			

From:

To: HRA

05/02/2008 15:38

#194 P.013/015

04/23/2008 03:00 FAX 2024428100

PRINTED: 04/23/2008  
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I 392	Continued From page 4  received the proper and necessary treatment as identified by his dentist to date.	I 392			
(I 401)	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS  Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.  This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the provision of timely and necessary dental services and treatment for one of eight residents residing in the facility. [Resident #1]  The findings include:  1. The facility failed to ensure Resident #1 received the proper and necessary dental services to prevent the deterioration of his oral health and loss of more teeth as required by this section. [Reference 3520.2(b)]  2. The facility also failed to ensure Resident #4 received the proper and necessary orthotic services to ensure the provision of a new leg brace. [Reference Federal Deficiency Report Citation W436]	(I 401)	Cross reference W159	5/15/08	
(I 422)	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.	(I 422)	Cross reference W159	5/15/08	

From:

To: HRA

05/02/2008 15:38

#194 P.014/015

05/23/2008 03:00 FAX 2024420000

AND

PRINTED: 04/23/2008  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(I 422)	<p>Continued From page 5</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to address the documented lack of progression by a resident on his self medication administration program one of eight residents residing in the facility. [Resident #1]</p> <p>The finding includes:</p> <p>The facility was previously cited for failing to ensure accurate documentation on a resident's program during the 2/14/2008 survey. The facility was previously cited for failing to meet the requirements as laid out in the Federal Deficiency Citation W252. Record review on 4/4/2008 at 3:48pm revealed Resident #1 has been refusing the first three steps of his self medication program since the date of survey. The first three steps of the self medication program are as follows:</p> <ol style="list-style-type: none"> <li>1. Approaches nurse for meds independently.</li> <li>2. Will pour cup of water for meds.</li> <li>3. Will punch out meds with physical assistance.</li> </ol> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) at 3:55pm revealed she was not aware Resident #1 was progressing poorly on his self medication program. The facility failed to ensure the necessary oversight and intervention to ensure the proper supports when a resident's was failing to show progress in a habilitation program.</p>	(I 422)			
(I 500)	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and</p>	(I 500)			

Health Regulation Administration  
STATE FORM

2008

JUL12

If continuation sheet 6 of 7

U4/23/2000 00:00 FAX 6464640400

4442

PRINTED: 04/23/2008  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(I 500)	Continued From page 6  protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the rights of each resident were protected in accordance with DCMR Title 7 Subsection D Chapter 13 (Formerly PL 2-137), this chapter and other applicable laws.  The findings include:  See federal deficiency report citations W149, W189, W257, W358 and W438.	(I 500)	Cross reference W149 and W159	5/15/08	

From:

To: HRA

05/02/2008 15:40

#193 P.002/016

US/23/2000 03:00 FAX 2024460400

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(W 000)	INITIAL COMMENTS  A follow-up to the 2/14/2008 recertification survey was initiated on 4/3/2008 and was completed on 4/4/2008. The survey was conducted to assess the level of compliance to the deficiencies cited in the previous report and as presented in their Plan of Correction (POC). The results of the survey were based on observation, staff interviews, as well as a review of the client and administrative records, including a review of the unusual incident reports.	(W 000)			
(W 149)	483.420(d)(1) STAFF TREATMENT OF CLIENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the implementation of its written policies and procedures as required by this section for all clients residing in the facility.  The finding includes:  The facility was cited during the 2/14/2008 survey for failing to implement policies on reporting of unusual incidents. The provider's Plan of Correction (POC) detailed that "in the future ... staff will be required to attend additional training on Incident Management Policies and reporting injuries to Nursing staff." Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/3/2008 at 3:11pm revealed there has been no training on the incident management policy or on the methodology of reporting injuries to the Nursing	(W 149)	The facility will provide training on incident management, and reporting injuries to nursing staff.	5/8/08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Constance A. Rees* *Program Director* *5-2-08*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

From:

To: HRA

06/02/2008 15:40

#193 P.003/015

04/23/2008 03:00 FAX 2024442940

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 149}	Continued From page 1	{W 149}			
{W 159}	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for two clients residing in the facility. [Clients #1 and #4]</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The Qualified Mental Retardation Professional (QMRP) failed to ensure staff received the proper and necessary training on a client's orthotic device. [Reference W189]</li> <li>2. The Qualified Mental Retardation Professional (QMRP) failed to ensure the proper oversight and monitoring of a client's failure to show progress on his habilitative programming. [Reference W257]</li> <li>3. The Qualified Mental Retardation Professional (QMRP) failed to ensure clients received the proper and necessary dental services. [Reference W356]</li> <li>4. The Qualified Mental Retardation Professional (QMRP) also failed to ensure client s received the proper and necessary adaptive equipment. [Reference W436]</li> </ol>	{W 159}	<ol style="list-style-type: none"> <li>1. Client #4 will receive orthotic devices when Medicaid authorize payment for the orthotic devices. The facility will provide written documentation indicating when Client#4 was measured for the orthotic devices.</li> <li>2. The nursing staff will provide documentation that Client#1 was unable to participate in his medication program due to his fractured toes.</li> <li>3. QMRP will provide documentation where Client#1 refused dental care twice. Client#1 will return to the dentist again in an attempt to provide him with dental care.</li> <li>4. Cross reference W159</li> </ol>	5/15/08	5/15/08



From:

To: HRA

05/02/2008 15:41

#193 P.004/015

04/23/2008 09:00 FAX 2024420400

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(W 189)	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that staff received the proper and necessary training on a client's adaptive equipment as required by this section for one of eight clients residing in the facility. [Client #4]</p> <p>The finding includes:</p> <p>The facility was cited during the 2/14/2008 survey for failing to ensure that staff received training on Client #4's adaptive equipment (gait belt and leg brace). The facility's Plan of Correction (POC) detailed that "the facility will train staff on how to assist [Client #4] in walking with the gait belt and putting on his braces." This corrective measure was to be completed by 3/19/2008.</p> <p>Client #4 was observed on the afternoon of 4/4/2008 wearing his gait belt but, he was without his leg brace. Staff was observed using the gait belt, but it was not clear why he was not wearing his leg brace. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 3:37pm revealed the leg braces were not available at the time of survey and that the provision of that orthotic device was pending. Record review revealed the facility was not able to complete the training on the use of the leg braces, being that the orthotic device has not been provided. [Reference W436]</p>	(W 189)	QMRP will provide training for staff once Client#4 receives his braces.	6/1/08	

From:

To: HRA

05/02/2008 15:41

#183 P.006/016

04/23/2008 03:56 FAX 2024428430

BAA

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE .3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 257	<p>483.440(f)(1)(iii) PROGRAM MONITORING &amp; CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to address the documented lack of progression by a client on his self medication administration program one of eight clients residing in the facility. [Client #1]</p> <p>The finding includes:</p> <p>The facility was previously cited for failing to ensure accurate documentation on a client's program during the 2/14/2008 survey. The facility was previously cited for failing to meet the requirements as laid out in W252. Record review on 4/4/2008 at 3:45pm revealed Client #1 has been refusing the first three steps of his self medication program since the date of survey. The first three steps of the self medication program are as follows:</p> <ol style="list-style-type: none"> <li>1. Approaches nurse for meds independently.</li> <li>2. Will pour cup of water for meds.</li> <li>3. Will punch out meds with physical assistance.</li> </ol> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) at 3:55pm revealed she was not aware Client #1 was progressing poorly on his self medication program. The facility failed to ensure the</p>	W 257	Cross reference W159	5/15/08	

From:

To: HRA

05/02/2008 15:41

#193 P.008/015

04/23/2008 09:00 FAX 2024420400

HRA

PRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  C M S			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 12TH STREET NW WASHINGTON, DC 20010		
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W 257  (W 356)	<p>Continued From page 4</p> <p>necessary oversight and intervention to ensure the proper supports when a client 's is failing to show progress in a habilitation program.</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT</p> <p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the provision of timely and necessary dental services and treatment for one of eight clients residing in the facility. (Client #1)</p> <p>The findings include:</p> <p>The facility was previously cited for not ensuring timely dental services for its residents. According to the citation levied during the 2/14/2008 survey, the facility took the client to receive dental services on 2/18/2007, 7/16/2007, and again on 1/29/2008, but the client did not received the following services. The reason(s) why the services were not render was unknown to the staff.</p> <ol style="list-style-type: none"> <li>1. Recommended to receive scaling due to heavy calculus deposits</li> <li>2. Recommended to receive partial denture</li> <li>3. Treatment to address Gingivitis</li> <li>4. Treatment to address the Carious lesion on Tooth #12</li> <li>5. Recommended to receive Prophylaxis and polishing</li> </ol>	W 257  (W 356)	Cross reference W159	5/15/08	

From:

To: HRA

05/02/2008 15:42

#193 P.007/D15

05/02/2008 03:31 FAX 2024940200

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  C M S			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 356}	Continued From page 5 6. Extraction of Tooth #12  The facility's Plan of Correction (POC) detailed that they would ensure that "Client #1 will return to the dentist for dental follow-up". This treatment was to be completed by 3/26/2008 as presented in their POC. Record review revealed Client #1 was taken for dental treatment on 3/5/2008, but he refused treatment. The dentist recommended during the 3/5/2008 consultation to have this client sedated prior to receiving treatment. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 4:16pm revealed that the Human Rights Committee (HRC) would have to approve the action, and then the client's brother would also have to consent. There is was no evidence presented on or file at the time of survey to substantiate that this client has received the proper and necessary treatment as identified by his dentist to date.	{W 356}			
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT  The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure the provision of a leg brace for one of eight clients residing in the facility. [Client #4]  The finding includes:	{W 436}	Cross reference W159	5/15/08	

From:

To: HRA

05/02/2008 15:42

#193 P.008/015

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008  
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NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
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{W 436}	Continued From page 6  Client #4 was observed on the afternoon of 4/4/2008 wearing his gait belt but, he was without his leg brace. Staff was observed using the gait belt, but it was not clear why he was not wearing his leg brace. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 3:37pm revealed the leg braces were not available at the time of survey and that the provision of that orthotic device was pending. Record review revealed that Client #4 was taken to an orthopedic specialist to be refitted for the new braces on 2/18/2008, but there was no evidence at the time of survey to substantiate that the facility followed through to ensure that this client received his adaptive equipment in a timely manner.	{W 436}			

From:

To: HRA

05/02/2008 15:42

#193 P.009/015

05/23/2008 05:21 PM 2008052300

PRINTED: 04/23/2008  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  08G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(1 000)	INITIAL COMMENTS  A follow-up to the 2/14/2008 licensure survey was initiated on 4/3/2008 and was completed on 4/4/2008. The survey was conducted to assess the level of compliance to the deficiencies cited in the previous report and as presented in their Plan of Correction (POC). The results of the survey were based on observation, staff interviews, as well as a review of the client and administrative records, including a review of the unusual incident reports.	(1 000)		
(1 090)	3504.1 HOUSEKEEPING  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the interior and exterior of each GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  The findings include:  Basement:  The carpet in the basement near the door leading to the laundry room appeared to be water damaged and stained as such.  First Floor:  1. No toilet tissue holder observed in the	(1 090)	Carpet will be replaced.          Toilet tissue holder and paper towel holder were installed.	5/15/08          4/28/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

DATE

JUL12

If continuation sheet 1 of 7

From:

To: HRA

05/02/2008 15:42

#193 P.010/015

04/23/2008 03:51 FAX 2024920930

JMS

PRINTED: 04/23/2008  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  C M S		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(I 090)	Continued From page 1  bathroom and no paper towel holder was available in the first floor bathroom.  2. New small areas of brown stains were again observed on the ceiling in the dining room. According to the Qualified Mental Retardation Professional (QMRP), the areas were previously repaired and she is not sure how or why the stains are returning.  Exterior:  1. Several torn areas were observed in the carpet installed on the steps leading to the front porch, which created a potential hazard.  2. A torn area was observed in the carpet where back porch is attached to the first step, which created a potential hazard.	(I 090)	Ceiling tiles were replaced.	4/30/08	
			Carpet was replaced.	4/7/08	
			Carpet was replaced.	4/7/08	
(I 222)	3510.3 STAFF TRAINING  There shall be continuous, ongoing in-service training programs scheduled for all personnel.  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that staff received the proper and necessary training on a resident's adaptive equipment as required by this section for one of eight residents residing in the facility. [Resident #4]  The finding includes:  The facility was cited during the 2/14/2008 survey for failing to ensure that staff received training on Resident #4's adaptive equipment (gait belt and leg brace). The facility's Plan of Correction (POC) detailed that "the facility will train staff on	(I 222)	Cross reference W159 Training was provided for the gait belt.  Training for braces will be completed when braces are in the facility.	5/15/08 3/19/08 6/1/08	

Health Regulation Administration  
STATE FORM

JUL12

If continuation sheet 2 of 7

From:

To: HRA

05/02/2008 15:43

#193 P.011/015

04/23/2008 03:57 FAX 2024429430

BAA

PRINTED: 04/23/2008  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE COMPLETE DATE	
(I 222)	Continued From page 2  how to assist [Resident #4] in walking with the gait belt and putting on his braces. " This corrective measure was to be completed by 3/19/2008.  Resident #4 was observed on the afternoon of 4/4/2008 wearing his gait belt but, he was without his leg brace. Staff was observed using the gait belt, but it was not clear why he was not wearing his leg brace. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 3:37pm revealed the leg braces were not available at the time of survey and that the provision of that orthotic device was pending. Record review revealed the facility was not able to complete the training on the use of the leg braces, being that the orthotic device has not been provided. [Reference W436]	(I 222)			
I 392	3520.2(b) PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:  (b) Dentistry,  This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the provision of timely and necessary dental services and treatment for one	I 392	Cross reference W159	5/15/08	



From:

To: HRA

05/02/2008 15:43

#183 P.012/015

04/23/2008 03:57 FAX 2024428430

BAA

PRINTED: 04/23/2008  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035		(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(K3) DATE SURVEY COMPLETED  R 04/04/2008	
NAME OF PROVIDER OR SUPPLIER  C M S				STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010			
(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(K6) COMPLETE DATE
1392	<p>Continued From page 3</p> <p>of eight residents residing in the facility. [Resident #1]</p> <p>The findings include:</p> <p>The facility was previously cited for not ensuring timely dental services for its residents. According to the citation levied during the 2/14/2008 survey, the facility took the resident to receive dental services on 2/18/2007, 7/18/2007, and again on 1/29/2008, but for some reason the resident never received the following services:</p> <ol style="list-style-type: none"> <li>1. Recommended to receive scaling due to heavy calculus deposits</li> <li>2. Recommended to receive partial denture</li> <li>3. Treatment to address Gingivitis</li> <li>4. Treatment to address the Carious lesion on Tooth #12</li> <li>5. Recommended to receive Prophylaxis and polishing</li> <li>6. Extraction of Tooth #12</li> </ol> <p>The facility's Plan of Correction (POC) detailed that they would ensure that "Resident #1 will return to the dentist for dental follow-up". This treatment was to be completed by 3/26/2008 as presented in their POC. Record review revealed Resident #1 was taken for dental treatment on 3/5/2008, but he refused treatment. The dentist recommended during the 3/5/2008 consultation to have this resident sedated prior to receiving treatment. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on 4/4/2008 at 4:18pm revealed that the Human Rights Committee (HRC) would have to approve the action, and then the resident's brother would also have to consent. There was no evidence presented on or file at the time of survey to substantiate that this resident has</p>			1392			

Health Regulation Administration  
STATE FORM

JUL12

If continuation sheet 4 of 7

From:

To: HRA

05/02/2008 15:43

#183 P.013/015

04/23/2008 03:00 FAX 2024429930

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PRINTED: 04/23/2008  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 392	Continued From page 4  received the proper and necessary treatment as identified by his dentist to date.	I 392			
(I 401)	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS  Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.  This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the provision of timely and necessary dental services and treatment for one of eight residents residing in the facility. [Resident #1]  The findings include:  1. The facility failed to ensure Resident #1 received the proper and necessary dental services to prevent the deterioration of his oral health and loss of more teeth as required by this section. [Reference 3520.2(b)]  2. The facility also failed to ensure Resident #4 received the proper and necessary orthotic services to ensure the provision of a new leg brace. [Reference Federal Deficiency Report Citation W436]	(I 401)	Cross reference W159	5/15/08	
(I 422)	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's individual Habilitation Plan.	(I 422)	Cross reference W159	5/15/08	

Health Regulation Administration  
STATE FORM

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JUL12

If continuation sheet 6 of 7

From:

To: HRA

06/02/2008 15:44

#183 P.014/015

04/23/2008 03:00 PM 2042442000

HRA

PRINTED: 04/23/2008  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  C M S			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
(I 422)	Continued From page 5  This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to address the documented lack of progression by a resident on his self medication administration program one of eight residents residing in the facility. [Resident #1]  The finding includes:  The facility was previously cited for failing to ensure accurate documentation on a resident's program during the 2/14/2008 survey. The facility was previously cited for failing to meet the requirements as laid out in the Federal Deficiency Citation W252. Record review on 4/4/2008 at 3:45pm revealed Resident #1 has been refusing the first three steps of his self medication program since the date of survey. The first three steps of the self medication program are as follows:  1. Approaches nurse for meds independently. 2. Will pour cup of water for meds. 3. Will punch out meds with physical assistance.  Interview with the facility's Qualified Mental Retardation Professional (QMRP) at 3:55pm revealed she was not aware Resident #1 was progressing poorly on his self medication program. The facility failed to ensure the necessary oversight and intervention to ensure the proper supports when a resident's was failing to show progress in a habilitation program.	(I 422)			
(I 500)	3523.1 RESIDENT'S RIGHTS  Each GHMRP residence director shall ensure that the rights of residents are observed and	(I 500)			

From:

To: HRA

05/02/2008 15:44

#193 P.015/015

05/23/2008 03:50 FAX 2024462430

MVA

PRINTED: 04/23/2008  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/04/2008
NAME OF PROVIDER OR SUPPLIER  CMS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(I 500)	Continued From page 6  protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the rights of each resident were protected in accordance with DCMR Title 7 Subsection D Chapter 13 (Formerly PL 2-137), this chapter and other applicable laws.  The findings include:  See federal deficiency report citations W149, W189, W257, W358 and W438.	(I 500)	Cross reference W149 and W159	5/15/08	

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health**



**Health Regulation Administration**



**SAMPLE SELECTION FORM**

Survey Period  
From: **March 25, 2009**  
To: **March 26, 2009**

<b>Provider Name:</b>	<b>DC Health Care</b> <b>4601 Georgia Avenue NW</b>	<b>Provider Number:</b>	<b>O9G-046</b>
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Names	Functional Level	Core	Add-On	Client Identifiers
DONALD MCCOY	PROFOUND	x		CLIENT #1
KENNETH BURGESS	SEVERE	x		CLIENT #2
PHILLIP ROSE	PROFOUND	x		CLIENT #3
MARCELLUS BRUCE	SEVERE	x		CLIENT #4
ROLAND MINOR	SEVERE	<input type="checkbox"/>	<input type="checkbox"/>	CLIENT #5
AARON COOPER	PROFOUND	<input type="checkbox"/>	<input type="checkbox"/>	CLIENT #6
MARK WILSON	PROFOUND	<input type="checkbox"/>	<input type="checkbox"/>	CLIENT #7

**Roland Follot/Michael D. Walker**  
\_\_\_\_\_  
Surveyor(s)

**March 26, 2009**  
\_\_\_\_\_  
Date